



UPDATE:

Workgroup on Person-
Centered Planning and Next
Steps Recommendations

January 28, 2009

**MICHIGAN LONG-TERM CARE SUPPORTS AND SERVICES
ADVISORY COMMISSION**



Workgroup Charge/Responsibility

- Evaluate the implementation of the Person Centered Planning process as it exists today; including the use of a *consumer chosen supports coordinator* and the process evident in the Medicaid Waiver Program, Single Point of Entry Process, and the LTC Connections sites.
- Review and Refine guidelines and protocols in a meaningful way so that implementation of the Person Centered Planning Process becomes operational in all long term care settings/service lines.
- Focus workgroup efforts on the importance of ongoing education on the core values and principles of Person Centered Planning.
- Identify increased opportunities for advancing and supporting the individual at all costs.



Workgroup Charge/Responsibility

- Determine a realistic next steps approach to moving Person Centered Planning into all aspects of long term care supports and services.
- Determine barriers to implementation and make recommendations for change.



Initial Workgroup Meetings Focused on:

- Gaining knowledge regarding Person Centered Planning effectiveness to date.
- Determining reasonable goals and objectives for the Person Centered Planning Workgroup and the Office of Long Term Care Supports and Services.
- Creating a mechanism for ongoing discussion about task timelines and objectives.
- Determining whether there was widespread workgroup membership, participation and stakeholder support.

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Initial Discussions

- Defined the nursing home as the most regulated and perhaps the most restrictive of the supports and services environment or programs.
- Recognized that conservatorships/guardianships were causing challenges to the implementation of a Person Centered Planning Process in all service sectors and programs and challenged proposed legislation counter to person centeredness



Shared Learnings

- There is a difference between a person centered environment and what is true Person Centered Planning.
- There is a recognition that regulatory interpretation by providers and surveyors may be a significant barrier to implementation of a true Person Centered Planning Process where the client is at the center of the planning process and where the client's needs, wants and desires are documented and realized on a daily basis.
- There was significant recognition that education of all stakeholders on the core values and principles must continue.
- There was a strong feeling expressed by workgroup members that a subgroup of nursing home providers could evaluate further the existence of the Person Centered Planning Process in a small sample of nursing homes.



Further Shared Learnings

- A set of core values or guiding principles should be established for use across the array of long term care services.
- The consumer may need to appoint a “champion” who understands the Person Centered Planning process.



Actions to Date

- Nursing home provider subgroup analyzed the existence of Person Centered Planning Process in a sample group of skilled nursing facilities where culture change had and had not been implemented.
- Continued monitoring of legislative actions related to guardianships/conservatorships.
- Obtained ongoing updates from sectors already engaged in PCP implementation.



Nursing Home Sub-Group Desired Outcomes

- Subgroup will provide a platform for further study and analysis.
- Workgroup will be able to identify barriers to implementation in a highly regulated setting and make several key recommendations back to the LTC Advisory Commission.



Nursing Home Sub-Group Update

- Person-centeredness focuses on individual strengths, skills, life accomplishments, and acknowledges individual needs and desires.
- A successful Person-Centered Planning process puts the individual in charge of their own life.
- The consumer of long-term care services who has significant cognitive impairment must be given the opportunity to make as many personal choices/decisions as possible.
- A consumer with cognitive limits may have a designated “champion” knowledgeable about the individual’s strengths, skills, desires, needs, etc.

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Nursing Home Sub-Group Work Plan

- Identify cyclical opportunities during a consumer’s “stay” when a Person Centered Planning process/approach is key to individual self-determination, choice, & empowerment.
- Remove perceived barriers created by regulators and nursing home providers that may limit the opportunity for true person- centered inquiry.
- Revisit core values, principles and essential elements.



Identified Stages/Cycles in Nursing Homes

- Public education/marketing materials which explain providers' commitment to the process.
- Admission Process
- Care planning process – long-term and short-term goals, life planning.
- Client evaluation process throughout the stay.



Work Plan for FY 2009

- Co-Chairs and OLTCSS
 - Pull Together materials
 - Policies Chart
 - Values and Elements
 - Training materials

- Update and Objectives
- Expand participation
- PAT and Commission Workgroup
 - Commission meets next: February 12, 2009 @ 10:00 AM @ ARC-MI Lansing office

Task Force Recommendation One: Require and Implement Person Centered Planning Practices
Draft 1.13.09

Goal: Increase consumer control over ltc decisions, planning and services through increase in provider adoption and practice of person centered planning process.					
Objective	Activity	Output	Outcome	Indicator/measures	Responsible for and time line
Develop and follow a process to build support for definition, core elements, and values that can be used across the array of services	<p>Meet with OLTCSS and Work group co-chairs for agreement on plan</p> <p>Share plan and definition/elements to workgroup</p> <p>Revised objectives and plan as needed</p>	Definition, value element statements,	<p>Workgroup participants, commission and OLTCSS involved in process</p> <p>Participants felt input heard and used</p> <p>LTC providers use core definition, values and elements in their planning</p>	<p>Commission adopts and recommends to state the definitions, values, elements</p> <p>State and providers adopt core principles, values and elements</p>	<p>Workgroup:</p> <p>Feb: Send recommendation to Commission</p> <p>March Adopted by Commission</p>
Increase awareness and support for PCP across state government and service array through OLTCSS and Commission efforts to inform, educate and receive ongoing input on implementation strategies and PCP products.	<p>Workgroup members share and advocate for use of adopted definition/values/elements</p> <p>Develop communication plan Which identifies target groups (state departments, state associations, Consumer Task Force) and materials.</p> <p>Implement plan</p> <p>Online training opportunity for state employees</p>	<p>Communication Plan</p> <p>Training/education sessions held</p> <p>Documents that describe PCP</p> <p>Multiple opportunities for input</p> <p>Evaluation of presentations</p> <p>Definition and values incorporated into DCH talking points</p>	<p>Target audience is aware and involved</p> <p>PCP documents are used</p>	Stakeholders indicate support of documents	

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Objective	Activity	Output	Outcome	Indicator/measures		Responsible for and time line
Prioritize Person Centered Planning process implementation activities and develop recommendations for strategies to foster adoption and change in policy, regulations, law etc.	<p>Prioritization process developed (workgroup-other?) and conducted</p> <p>Revise health facility and professional licensing, certification criteria, and continuing education requirements to reflect a commitment to organizational culture change, person-centered processes, cultural competency, cultural sensitivity, and other best practices. z</p>	LTC stakeholder begins adoption process	<p>Policy change</p> <p>Law change</p>			
A curriculum and training materials and dissemination strategies will be developed	<p>Create representative subcommittee to develop, organize, make available and sanction training materials</p> <p>Incorporate PCP training materials into</p>	Training curricula that includes various levels and types of providers/individuals tools and products,	<p># number of trained persons</p> <p># number of persons respond to survey that reflects assistance was provided use PCP values and elements</p>	survey		

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Objective	Activity	Output	Outcome	Indicator/measures		Responsible for and time line
	BHS CEU and NH administrator course and other existing training curriculum and requirements	and is population specific: Develop training curricula tool kit (videos, talking books, written material, CD, web-based, etc.) Create an training evaluation form				
Recommendations for resource allocation to support this effort will be made						
Recommendations to the OLTCSS Quality Management plan will be provided. Activities will be coordinated with other Commission workgroups including the QM group.	Participate in development of QM plan so uniform questions are asked over time and across the array. Evaluate implementation for quality of life changes and system reform		Participants in PCP report that the process was effective			
Include PCP principles in	Identify other state					

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Objective	Activity	Output	Outcome	Indicator/measures		Responsible for and time line
model legislation to amend the Public Health Code	legislation Workgroup meet with legislative advocates and DCH staff to review process					

PERSON CENTERED PLANNING PRINCIPALS/CHARACTERISTICS

CMS Self-Directed Final Rule	Practice Guidance for the MI Choice Waiver Sites June 2008	Medicaid Provider Manual – Nursing Facility Coverages Sec 6.1 7.1.2008	DHS Adult Services Manual – Independent Living Services Program Overview (ASM 361)	Aging – Nursing Home Diversion Grant	Mental Health - Person-Centered Planning Revised Practice Guideline-
<p>1. The person's activities, services and supports are based on his or her dreams, interests, preferences, strengths, and capacities</p>	<p>1. Person-centered planning is an individualized process designed to respond to the preferences and desires of the individual</p> <p>2. Each individual has strengths and the ability to express preferences and make choices.</p> <p>6. A person's cultural background shall be recognized and valued in the planning process.</p>	<p>1. Each individual has unique strengths, abilities and preferences and is able to express preferences and make choices. Each individual can participate in planning his life, with appropriate support if needed.</p>	<p>1. Person-centered, strength-based case planning focuses on: Client as decision-maker in determining needs and case planning. Client strengths and successes, instead of problems. Client as their own best resource. Client empowerment.</p>		<p>1. Each individual has strengths, and the ability to express preferences and to make choices.</p> <p>5. A person's cultural background shall be recognized and valued in the decision-making process.</p>
<p>2. The person and people important to him or her are included in planning, and have the opportunity to exercise control and make informed decisions</p>		<p>2. People trusted by the individual and committed to supporting the individual's choices must be involved in planning for long-term care. The process is dependent on the participation of supportive relationships, such as family members and friends, and encourages their involvement, to the extent that the choices of the individual are reflected. These relationships support the individual's right to choose, even the right to take risks.</p>			
<p>3. The person has meaningful choices, with decisions based on his or her experiences</p>	<p>3. The individual's choices and preferences shall always be honored and considered.</p>				<p>2. The individual's choices and preferences shall always be honored and considered, if not always granted.</p>
<p>4. The person uses, when possible, natural and community supports</p>					
<p>5. Activities, supports and services foster skills to achieve personal relationships, community</p>	<p>4. Each individual can contribute to the community, and has the ability to choose how supports and services</p>				<p>3. Each individual has gifts and contributions to offer to the community, and has the ability to choose how</p>

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inclusion, dignity, and respect	may help them meaningfully participate in and contribute to the community. 5. Person-centered planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals, and desires.				supports, services and/or treatment may help them utilize their gifts and make contributions to community life.
6. The person's opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints					4. Person-centered planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals and desires.
7. Planning is collaborative, recurring, and involves an ongoing commitment to the person					
8. The person is satisfied with his or her activities, supports and services				3. Person-centered planning is outcome-oriented. The planning should lead to positive outcomes in the individual's life, i.e., helping to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The individual determines what constitutes a positive outcome. For a younger adult with a disability, this may include building a career. For an older person near the end of life, the positive outcomes may include deciding where one dies and who is present.	

Person-Centered Planning Across the Array

Core Elements and Implementation Plan

January 28, 2009

CONCEPTUAL SUMMARY

The role of the Person-Centered Planning process in long-term care services is to assist individuals in meeting their needs in ways that support the individual's life, personal goals and choices. It is essential that allies and professionals understand the core aspects of the Person-Centered Planning process. Following a Person-Centered Planning process methodology allows for:

- Helping the individual clarify and express goals and choices,
- Helping allies and professionals understand the individual's life goals and choices, and
- Helping all participants understand how services and supports help the individual attain their goals and choices.

During this past year, several steps have been taken to implement Person Centered Planning in the full array of long term care supports and services:

- The Office of Long Term Care Supports and Services (OLTCSS) in conjunction with MI Choice staff and a broad stakeholder workgroup revised MI Choice Waiver standards and the state incorporated these standards into contract requirements.
- The Office of Services to the Aging is implementing change within the Older American Act standards.
- The Person Centered Planning Workgroup of the Long Term Care Advisory Commission has initiated change pilot projects in several nursing homes and has taken an aggressive stance to protect an individual's rights and choices by challenging harmful legislation related to guardianship and conservator appointments.

IMPLEMENTATION/WORK PLAN

Because much work has already been done to define PCP, our work will focus on implementation strategies so that person centered practices are evident across the continuum.

The OLTCSS in conjunction with the Commission Workgroup plan to:

- Acknowledge and build on the foundation already established in Michigan.
- Increase awareness and understanding of current policy, requirements and initiatives related to person centered planning practices; identify best practices and skilled practitioners, and identify barriers to expanding use of PCP.
- Engage long term care/disability network/continuum stakeholders in dialogue about how PCP Process can be implemented and shared across

agencies/organizations including ongoing dissemination of successes and mobilization of stakeholders when difficulties arise.

- Achieve consensus on the definitions, values and elements for Person-Centered planning processes which can be incorporated across the continuum.

Definition, Core Values/Principles and Essential Elements
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Definition

"Person-Centered Planning" means a process for planning and supporting the consumer receiving services that builds on the individual's capacity to engage in activities that promote community life and that honors the consumer's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the consumer desires or requires. (PA 634 **Sec. 109i** (23) f)

Core Values and Principles

The Person-Centered Planning process is based on the following values and principles:

- Person-Centered Planning is an individualized process designed to respond to the preferences and desires of the individual.
- The person and (if desired) people important to him or her are included in planning.
- Each individual has strengths and the ability to express preferences and make choices.
- The individual's choices and preferences shall always be honored and considered.
- The person uses, when desired and available natural and community supports.
- Each individual can contribute to the community, and has the ability to choose how supports and services may help them meaningfully participate in and contribute to the community.
- Person-Centered Planning processes maximize independence, create or maintain community connections, and work towards achieving the individual's dreams, goals, and desires.
- A person's cultural background shall be recognized and valued in the planning process.
- The planning process is supportive of the person and their wishes, collaborative, reoccurring and involves an ongoing commitment to the whole person.

Essential Elements

The Person-Centered Planning process includes the following:

- *Person-Directed.* The individual controls the planning process.
- *Capacity Building.* Planning focuses on an individual's gifts, abilities, talents, and skills rather than deficits.
- *Person-Centered.* The focus is continually on the individual's life with whom the plan is being developed and not on fitting the person into available services and supports in a standard program.
- *Outcome-Based.* The planning process focuses on increasing the experiences identified as valuable by the individual during the planning process.
- *Presumed Competence.* All individuals are presumed to have the capacity to actively participate in the planning process (even individuals with cognitive and/or mental disabilities are presumed to have capacity to participate).
- *Information.* A PCP approach must address the individual's need for information, guidance, and support.
- *Facilitation.* Individuals may choose to have an independent advocate/champion to act as facilitator. Facilitation may include pre-planning and conducting the planning meetings. This may be done more effectively by someone outside of the provider organization
- *Participation of Allies.* For most individuals, person-centered planning relies on the participation of allies chosen by the individual, based on whom they feel is important to be there to support them.
- *Health and Welfare.* The needs of the individual must be addressed in a person centered manor, strategies to address identified health and welfare needs are supported to allow the individual to maintain his/her life in the setting of his/her choice.
- *Documentation.* The planning results should be documented in ways that are meaningful to the individual and useful to people with responsibilities for implementing the plan.

PCP Workgroup and OLTCSS 2009 Goals and Objectives

During FY 2009 Planning and Implementation activities will:

- Develop and follow a process to build support for the definition, core elements, and values that can be used across the array of services.
- Increase awareness and support for PCP across state government and service array through OLTCSS and Commission efforts to inform, educate and receive ongoing input on implementation strategies and PCP products.
- Prioritize Person Centered Planning process implementation activities and develop recommendations for strategies to foster adoption and change in policy, regulations, law, etc.
- Develop curriculum and training materials and dissemination strategies.
- Recommendation resource allocation to support effort.
- Identify benchmark indicators, quality measurements and methods as part of a collaboration between the OLTCSS Evaluation and Quality Improvement Section and the related Commission Workgroups. Activities will be coordinated with other Commission workgroups including the Quality Management System workgroup.

Educational Materials

- Core values, definition, elements
- Changes in rules, etc
- Changes in law
- Training materials and curriculum
- Training conducted
- Measures and plan for data collection
- Persons experience changes

Planning Team, Consultants and Future Participants

Workgroup:

- Dohn Hoyle
- Denise Rabidoux
- Consumers
- Tari Muniz
- Jane Alexander, OLTCSS
- Nora Barkey, OLTCSS
- Pam McNab, OLTCSS—or QA person
- Susan Yontz, MSA, Policy
- Loni Heckney, MSA
- Marion Killingsworth, MSA
- Tiffany Romelus MSA

- Deb Katcher MSA
- Mike Daeschlein, MSA, MI Choice
- Mike Head, Mental Health
- Barb Anders, DHS
- Cynthia Farrell, DHS
- Wendy Middleton, OSA
- Dave Herbel, MAHSA
- Pat Anderson, HCAM
- Dave LaLumia, HCAM
- MALA
- Tricia Harney
- Jeff Towns Michigan Hospice and Palliative Care Organization
- Kianna Harrison
- Regional LTCC representative
- AAA representative
- CIL representative
- PACE representative
- Hospital representative
- Roxanne Chang
- Vicki Clark
- Representative from Ombudsman program
- Andy Farmer
- Vivian Roder (Hospital)

Other ideas?

Person-Centered Planning Across the Array

Core Elements and Implementation Plan

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APPENDIX

BACKGROUND INFORMATION

The LTC array of services is made up of a diverse and broad range of agencies, programs, businesses, state bureaucracies, and persons each with its unique role and responsibility, therefore to meet this goal and assure that “individual’s preferences, choices, and abilities are honored ” when accessing information and supports and/or moving within and between the fragmented acute and long term services will require continuing collaborative efforts.

There is a growing body of research on quality of life and care showing improved outcomes occur when individuals have information, control, choice and the ability to build on strengths, set goals and maintain or create connections and relationships that provide meaning.

This OLTCSS plan is based on these mandates and the research results.

The movement toward Person-Centered Planning has been growing in Michigan for the past three decades. The Howell group adopted a definition and identified characteristics in October 1994. This work provides the basis for subsequent work. In 1996, legislation was passed that required individuals receiving supports and services in the public mental health system to develop an individual plan of services using a Person-Centered Planning process. In January 2006 PA 634 was enacted, it requires Michigan’s access sites to provide person-centered planning. A definition of Person Centered Planning is included in the law.

Similarly, the Medicaid Long-Term Care Task Force report identified Person-Centered Planning as a central policy recommendation: “Require and implement person-centered planning practices throughout the Long Term Care (LTC) continuum and honor the individual’s preferences, choices, and abilities.”